emailed validation letter 10/26/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10.10.11
Amount $450.-

Ck# 481431

I. IDENTIFICATION

Name THE TRANSITIONAL CARE CENTER OF OWENSBORO

Address 811 EAST PARRISH AVE

City/County/Zip OWENSBORO / DAVIESS / 42303

Telephone number 270-688-3300

Administrator JOY EVERLY

Date facility operation began at current address HOSPITAL - 1898

Date facility began operation under current owner HOSPITAL - 1898

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OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	30	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
(Private)

Profit
(Nonprofit)

Individual
Partnership
(Corporation)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation OWENSBORO MEDICAL HEALTH SYSTEM, INC.

Address of corporation 811 EAST PARRISH AVE

President or Chairman BILLY JOE MILES

Vice President ALAN BRADEN

Secretary ANN MURPHY KINCHELOE

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Joy Eveily RN MSN, MA, NHA — DIRECTOR, EXTENDED CARE SERVICES — 10/5/11

Signature of authorized representative — Title — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

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(10/2002)